Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: October 1, 2024
Inspection Number: 2024-1233-0001
Inspection Type: Critical Incident
Licensee: Rykka Care Centres LP
Long Term Care Home and City: Dundurn Place Care Centre, Hamilton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 10-13, and 16-18, 2024.

The following intake(s) were inspected:

- Intake: #00111329 - CI-2739-000004-24 - COVID 19 - Outbreak declared on March 13, 2024, and finalized March 25, 2024.
- Intake: #00118136 - CI-2739-000007-24 - Related to Improper/Incompetent treatment of a resident.
- Intake: #00118578 -CI- 2739-000008-24 - Related to Sexual abuse of a resident by a resident.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The licensee has failed to ensure that their policy for the prevention of abuse and neglect was complied with.

Rationale and Summary
On a specified day in June 2024, a staff member witnessed an incident of sexual abuse. They observed a resident touch another resident in an inappropriate way. The staff member notified the staff member in charge. The staff member in charge spoke to the resident who was inappropriately touched by the other resident. The resident did not want the police called. The DOC (Director of Care) was immediately notified of the incident.

On a specified date in September 2024, in an interview, the DOC was asked if the police were notified. They advised the resident who was touched in an inappropriate way makes their own decisions. The police were not notified, the resident decided that for themselves. The DOC reported, staff offered to call the police for the resident many times. On a specified day in September 2024, the DOC reported calling the police against the wishes of the resident would have violated the resident's rights. They did not believe that the incident constituted a criminal offense due to the medical history of the resident who inappropriately touched them.

On a specified date in September 2024, the DOC acknowledged the homes policy for Abuse and Neglect states that the Executive Director will immediately notify the police of any alleged, suspected or witnessed incident of abuse or neglect of a resident, for the police to determine if the abuse constitutes a criminal offense.

Failure to ensure the homes policy for Abuse and Neglect was complied with, by not informing the police about an incident of abuse, did not allow a resident to exercise their right to press charges.

Sources: The homes policy for Abuse and Neglect, interviews with staff and the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff use safe positioning techniques when assisting residents.

Rationale and Summary
An assessment by a staff member completed on a specified day in January 2024, noted, a resident required total assistance for bed mobility. The resident needed two-person assistance.
On a specified day in June 2024, the resident was transferred to their bed by two staff members using a lift. A staff member who assisted with the transfer of the resident left the other staff member alone to assist the resident with bed mobility and one person. The resident fell from their bed when assisted by one person. The resident was injured, and they were transferred to the hospital.

On a specified day in September 2024, the DOC advised in their investigation, both staff members involved were aware the resident required two-person assistance for bed mobility. It was noted in residents care plan.

Failure to ensure staff used safe positioning techniques when assisting a resident caused actual harm and put the resident at further risk for injury.

Sources: The resident's clinical record, interviews with staff and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program

s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, was implemented.

A) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary
During observations on a specified date in September 2024, a staff member was observed exiting a resident's room. The resident was on additional precautions, there was signage on their door. The staff member exited the room, wearing gloves and went down the hallway into another resident's room wearing soiled gloves and holding a wet brief.
During an interview with the staff member, they confirmed they left the residents room wearing gloves and entered another resident's room with the soiled gloves on. The staff member did not perform hand hygiene after providing care to the first resident and having contact with their environment. They did not perform hand hygiene prior to entering the environment and room of another resident.

On a specified date in September 2024, in an interview, the IPAC (infection prevention and control) lead verified that the staff member did not follow the four moments of hand hygiene as per the hand hygiene program.

Failure to follow the four moments of hand hygiene put residents and staff at risk for infection.

Sources: Observations of a staff member, the homes policy on Hand hygiene and glove use, interviews with the staff member and the IPAC lead.

B) The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (d) proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal.

Rationale and Summary
During observations on a specified day in September 2024, a staff member was observed exiting a resident's room. The staff member was observed wearing gloves and holding a soiled brief. Signage for additional precautions was on the resident's door advising staff of what personal protective equipment was required. The staff member left the resident's room and entered a different resident's room, who was also on precautions. The staff member confirmed in an interview that they did not dispose of PPE and the soiled brief as required. The staff member confirmed they did not wear the required PPE when providing care to the first resident.

On a specified day in September 2024, the IPAC lead confirmed that the staff member did not wear the appropriate PPE. They did not discard their soiled PPE as required; they did not follow the identified precautions.

Failure to ensure precautions were followed posed a risk of spreading infection to staff and other residents.

Sources: Observations and interviews of a staff member. Interviews with the IPAC

lead.

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